Phone: 303-871-2723 **GENERAL HEALTH APPRAISAL FORM** Fax: 303-871-7805

PARENT please complete AND SIGN Fisher Early Learning Center

Child's Name:_____ **Birthdate:** _____

Allergies: ❑ None or Describe_____

Type of Reaction _____

Diet: ❑ **Breast Fed** ❑ **Formula** _____ ❑**Age Appropriate**

❑**Special Diet** _____

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

❑ **Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.**

I, _____ **give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #:** _____ **DATE:** _____

Parent/Guardian Signature_____

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: _____ **Weight @ Exam:** _____

Physical Exam: ❑ **Normal** ❑ **Abnormal** (Specify any physical abnormalities)_____

Allergies: ❑ None or Describe_____ Type of Reaction _____

Significant Health Concerns: ❑Severe Allergies ❑Reactive Airway Disease ❑Asthma ❑Seizures ❑Diabetes ❑Hospitalizations ❑Developmental Delays ❑Behavior Concerns ❑Vision ❑Hearing ❑Dental ❑Nutrition ❑ Other _____

Explain above concern (if necessary, include instructions to care providers): _____

Current Medications/Special Diet: ❑ None or Describe _____

Separate medication authorization form is required for medications given in school, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

❑Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

OR ❑Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

Immunizations: ❑Up-to-Date ❑ See attached immunization record ❑Administered today: _____

Health Care Provider: Complete if Appropriate

****ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE****

**** Height @ Exam _____ ** B/P _____ **Head Circumference (up to 12 months) _____ ****

**** HCT/HGB _____ ** Lead Level ❑Not at risk or Level _____**

****TB ❑Not at risk or Test Results ❑** Normal ❑ Abnormal

****Screenings Performed: ❑Vision:** ❑Normal ❑Abnormal **❑Hearing:** ❑Normal ❑Abnormal **❑Dental:** ❑Normal ❑Abnormal-

Recommended Follow-up_____

Provider Signature

Next Well Visit: ❑ Per AAP guidelines* or ❑ Age_____

This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.

_____

Signature of Health Care Provider (certifying form was reviewed) Date: _____

Office Stamp
Or write Name, Address, Phone, #

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07

*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

CERTIFICATE OF IMMUNIZATION
www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

Colorado law requires this form to be completed by a school health authority or health care provider for each immunized student attending Colorado schools.

6 CCR 1009-2 The Infant Immunization Program and Immunization of Students Attending School: Schools shall have on file an official immunization record for every student enrolled.

Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Each immunization date MM/DD/YY						Titer date
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
DT Diphtheria, Tetanus (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella date of disease	
Varicella positive screen date	

Recommended vaccines

	Each immunization date MM/DD/YY					
HPV Human Papillomavirus						
Rota Rotavirus						
MCV4/MPSV4 Meningococcal						
Men B Meningococcal						
Hep A Hepatitis A						
Flu Influenza						
Other						

Optional review signature by the school health authority or health care provider
I have reviewed this immunization record

Signature: _____ Date: _____

(Optional) TO BE COMPLETED BY PARENT/GUARDIAN/ADULT STUDENT
I authorize my/my student's school to share my/my student's immunization records with state/local public health and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Signature: _____ Date: _____

Revised September 2016